



Michigan Progressive Health

Megan Oxley, MD

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Authorization to Release / Obtain Medical Records

Patient Name: _____ Date of Birth: _____

Preferred Phone: _____

I hereby authorize Michigan Progressive Health (Medical Providers and Therapists) to:

Release Protected Health Information from my medical records to: **Obtain** Protected Health Information from my medical records from:

Name: _____ Phone/Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

INFORMATION TO BE RELEASED OR ACCESSED IN EITHER VERBAL OR WRITTEN FORM

All medical records including diagnostic evaluation, progress notes, phone calls, labs, consults
And neuroimaging reports. This does not include any records designated as psychotherapy notes. _____
Dates of Service: _____

Medication records only Labs and imaging studies only The following specific info only: _____

Purpose of Disclosure:

- | | | |
|---|--|---|
| <input type="checkbox"/> Coordination of Care | <input type="checkbox"/> School / College | <input type="checkbox"/> Family Member Access to Treatment |
| <input type="checkbox"/> Consult/Second opinion | <input type="checkbox"/> FMLA / Disability | <input type="checkbox"/> Insurance application (e.g., long-term care) |
| <input type="checkbox"/> Transfer of Care | <input type="checkbox"/> Other: _____ | |

- I understand that this authorization will expire one year after I have signed this form, or as specified here: _____
- I understand that I may revoke this authorization at any time by notifying Michigan Progressive Health or the other clinician or organizational provider in writing, and my revocation will be effective on the date notified except to the extent action has already been taken in reliance upon it.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by privacy regulations.
- I understand that I am not required to sign this form in order to receive treatment.
- I understand that there may be a fee for a copy of my medical record.
- I understand that information to be released or obtained may include mental health information in accordance with CGS 52-146(d), substance abuse treatment information in accordance with 42 CFR 2.1-2.67, and/or HIV/AIDS-related information in accordance with CGS 19a-585(a), except as indicated below.

<input type="checkbox"/> No Substance Abuse treatment should be disclosed	<input type="checkbox"/> No HIV/AIDS information should be disclosed
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Signature of Patient _____ Date

Print Name _____

Parent/Legal Guardian/Authorized Person _____ Date

Please send to:

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Email:
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annarbor@michiganprogressivehealth.com